Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Oriahnn (Elagolix, Estradiol and Norethindrone) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Oriahnn (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
ORIAHNN 300-1-0.5 MG/300 MG CAPS

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of uterine leiomyoma in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have 1 claim for a contraceptive agent in the last 180 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a diagnosis of osteoporosis in the last 365 days? Y N

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Does the patient have 1 claim for a strong OATP–1B1 inhibitor in the last 90 days (see Table A)? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.

7. Does the patient have a diagnosis of hepatic impairment in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 8.

8. Does the patient have a history of arterial, venous thrombotic or thromboembolic disorder in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Is the patient greater than 35 years of age? Y N
If the answer to this question is yes, go to question 10
If the answer to this question is no, go to question 11.

10. Is the patient a current smoker? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 11.

11. Does the patient have a diagnosis of uncontrolled hypertension in the last 180 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 12.

12. Has the patient had a confirmed suicide attempt in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 13.

13. Does the patient have a diagnosis of breast cancer or other hormonally sensitive cancer in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 14.

14. Is the dose per day less than or equal to 2 capsules daily? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

15. Has the patient had more than 24 months of elagolix/estradiol/norethindrone therapy? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 16.

16. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 17.
If the answer to this question is no, approved for 365 days.

17. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 18.

18. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 19.

19. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N

If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Table A
CYCLOSPORINE SOLUTION
CYCLOSPORINE CAPSULE
CYCLOSPORINE MODIFIED
GEMFIBROZIL 600 MG TABLET
GENGRAF SOLUTION
GENGRAF CAPSULE
LOPID 600 MG TABLET
NEORAL SOLUTION
NEORAL CAPSULE
PROMACTA TABLET
PROMACTA SUSPEN PACKET
RIFADIN CAPSULE
RIFADIN IV VIAL
RIFAMATE CAPSULE
RIFAMPIN CAPSULE
SANDIMMUNE CAPSULE
SANDIMMUNE SOLUTION

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date